South Carolina Workers' Compensation Commission
1612 Marion Street • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

Physician's Statement

Claimant's Name: _____

Physician's Name: _____

Practice/Clinic: _____

Preparer's Name: _____

Phone: (___) _____ - _____

Employer's Name: _____

Insurance Carrier: _____

SCWCC File No: _____

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to**§§42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: _____

Date of first office visit: _____ Date of last visit: _____

Diagnosis or nature of injury or illness: _____

Body part(s) injured: _____ _____Body part(s) affected: _____

Date of **Maximum Medical Improvement**: _____

Based on the **AMA Guidelines**, the claimant has sustained a _____**% medical impairment** to_____ injured body part(s) and a _____**% medical impairment** to_____ _____other affected body part(s).

_____The claimant is **able to return to work** without restriction.

_____The claimant is **able** to return to work **with the following restrictions:**

_____

_____

_____The claimant is **unable to return to work** at his or her current employment.

As of the date I last saw this patient, it is **my professional medical opinion** the claimant:

____**will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

_____**will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

_____

_____

_____

_____ _____

Treating Physician **Date**